STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012	
		100190	B. WING		04/02/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE HANNA AVE	
ALTENH	EIM HEALTH & LIV	VING COMMUNITY		IAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
1 0000					
	 This visit was fo	or a Recertification and	F0000		
		Survey. This visit			
		restigation of Complaint			
	IN00105408.	estigation of complaint			
	Complaint IN00	0105408 substantiated,			
		eficiencies related to the			
	allegations are o	cited at F323.			
	Survey dates: March 26, 27, 28, 29, 30,				
	and April 2, 201				
	_				
	Facility number	: 000103			
	Provider numbe	er: 155196			
	AIM number: 1	00290000			
	Survey Team:				
	Beth Walsh, RN	I, TC			
	Courtney Mujic	, RN			
	Karina Gates, M				
	Barbara Hughes				
	Lora Brettnache	er, RN			
	Census bed type	2 :			
	SNF/NF: 71				
	Residential: 59				
	Total: 130				
	Census payor ty	vpe:			
	Medicare: 19				
	Medicaid: 31				
	Other: 80				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155196	A. BUILDING B. WING	00 		LETED 2/2012
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	STREET A 3525 E I	DDRESS, CITY, STATE, ZIP COI HANNA AVE APOLIS, IN 46237	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Total: 130 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 4/8/12 Cathy Emswiller RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 2 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
		155196	A. BUILDING	·	04/02/2012
			B. WING	ADDRESS SITE STATE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
		(INC. 0.01414 INUT) (HANNA AVE	
ALIENHI	EIM HEALTH & LIV	/ING COMMUNITY	INDIAN	IAPOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0156	483.10(b)(5) - (1	10), 483.10(b)(1)			
SS=A		GHTS, RULES, SERVICES,			
	CHARGES				
	The facility mus	t inform the resident both			
	orally and in wri	ting in a language that the			
		tands of his or her rights and			
	_	ulations governing resident			
		sponsibilities during the stay in			
		facility must also provide the			
		e notice (if any) of the State			
		er §1919(e)(6) of the Act.			
		n must be made prior to or			
		and during the resident's f such information, and any			
		it, must be acknowledged in			
	writing.	it, must be acknowledged in			
	witting.				
	The facility mus	t inform each resident who is			
		caid benefits, in writing, at the			
		on to the nursing facility or,			
		nt becomes eligible for			
	Medicaid of the	items and services that are			
	included in nurs	ing facility services under the			
		or which the resident may not			
		se other items and services			
		offers and for which the			
		charged, and the amount of			
		se services; and inform each			
		hanges are made to the items			
	·	ecified in paragraphs (5)(i)(A)			
	and (B) of this s	ection.			
	The facility masses	t inform agab regident before			
		t inform each resident before, admission, and periodically			
		ent's stay, of services			
		facility and of charges for			
		including any charges for			
		rered under Medicare or by			
	the facility's per				
	The facility mus	t furnish a written description			
	of legal rights w				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 3 of 78

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155196	B. WIN			04/02/	2012
		<u> </u>	b. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R		1	HANNA AVE		
AI TENHI	FIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
					74 0207		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CO		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
		the manner of protecting					
	personal funds, under paragraph (c) of this section;						
	0000011,						
	A description of the requirements and						
	procedures for e	establishing eligibility for					
		ing the right to request an					
		ler section 1924(c) which					
		extent of a couple's					
	•	ources at the time of on and attributes to the					
		ise an equitable share of					
		cannot be considered					
	available for pay	ment toward the cost of the					
	institutionalized spouse's medical care in his or her process of spending down to Medicaid						
	eligibility levels.						
	A posting of pan	nes, addresses, and					
	. •	ers of all pertinent State					
	•	groups such as the State					
		fication agency, the State					
	-	the State ombudsman					
		otection and advocacy					
	· ·	e Medicaid fraud control unit;					
		that the resident may file a					
	•	ne State survey and					
	_	ncy concerning resident and misappropriation of					
		y in the facility, and					
		with the advance directives					
	requirements.						
		comply with the					
		ecified in subpart I of part					
	•	ter related to maintaining and procedures regarding					
		res. These requirements					
		ns to inform and provide					
	•	on to all adult residents					
		ight to accept or refuse					
		cal treatment and, at the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 4 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155196	B. WING		04/02/2012
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
A1 TEN111		VINIO COMBALINITY		HANNA AVE	
	EIM HEALTH & LIV	ING COMMUNITY		NAPOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	individual's optic directive. This ir of the facility's prodirectives and appropriate in the facility must name, specialty, physician responsive in the facility must facility written intresidents and appropriate in the facility written intresidents and appropriate in the facility f	in, formulate an advance includes a written description olicies to implement advance opplicable State law. Inform each resident of the and way of contacting the insible for his or her care. In prominently display in the formation, and provide to opplicants for admission oral mation about how to apply for re and Medicaid benefits, and efunds for previous payments in benefits. In the facility is a mount for her in the facility. This is dedicare beneficiaries a past 6 months who were propriate liability and (Resident #33)	F0156	This plan of correction is to serve a Altenheim Health and Living Community's credible allegation or compliance. Submission of this plat of correction does not constitute a admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing services in this facility. Not does this submission constitute and agreement or admission of the survey allegations. F156-483.10 (b) (5) - (10), 483.10 (b) (1) NOTICE OF RIGHTS, RULES, SERVICES CHARGES I. Resident # 33 is currently private pay. II. All residents	DATE DATE DATE DATE DATE
	_	nt #33's last day of		and/or legal representative discharging from Medicare	will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 5 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUILDING	00	COMPLETED 04/02/2012
		155196	B. WING		04/02/2012
	PROVIDER OR SUPPLIE IEIM HEALTH & LIV	R VING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	private pay on 1 Resident #33 di and appeals not	age was 1/30/12 and went /31/12. She indicated d not receive a liability ice nor was she notified at specific liability amount stay.		be informed in writing timely by the Business Office Manager regarding a Notice Non-Coverage, potential liability, and appeals rights according to regulations. III. The systemic change will include that the Business Office Manager will maintain a log of Medicare A residents indicating the resident's name, last covered day, and date of the Notice of Medicare Provider of Non-Coverage letter. Residents that are approach their last covered day for Medicare are discussed at the daily department head meeti (Monday through Friday) to monitor for timely issuance of a Medicare Denial letter. Education was provided to the Business Office Manager and members of the Department Head meeting regarding the systemic change. IV. The Administrate or her designee will audit for the Business Office Manager providing the Notice to the Resident/Legal Representati in a timely manner. Weekly audits will be conducted for months and monthly thereaf to ensure the Liability Notice and Beneficiary Appeal Righ are reviewed and followed accordingly. The Administrator or her designee	I dor ing lee ng of he d

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 6 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO	00 	(x3) DATE SURVEY COMPLETED 04/02/2012			
	ROVIDER OR SUPPLIEF		B. WING 04/02/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	will provide results of al and they will be reviewe discussed at the month! Quality Assurance Community and duration of results will be adjusted a needed. Completion date: April 2 2012	I audits d and y mittee the as		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 7 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00		X3) DATE SURVEY COMPLETED			
ANDILAN	or connection	155196	A. BUILDING ————————————————————————————————————				
		100100	B. WIN			04/02/2012	
NAME OF P	ROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP CODE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X:	5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLE	ETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Έ
F0248 SS=E	EACH RES The facility must program of activi accordance with assessment, the	provide for an ongoing ities designed to meet, in the comprehensive interests and the physical, chosocial well-being of each					
	resident.	chosocial well-being of each					
		ation, interview, and	F02	48	F248-483.15 (f) (1)	04/29/	2012
	record review, th	e facility failed to			ACTIVITIES MEET INTERESTS/NEEDS	-	
	provide activities	s designed to meet the			OF EACH RES		
	assessed needs for	or 5 of 6 residents			I. Residents #29, #37, #26, (residents, # 129 & # 6 are no	&	
	reviewed for activities (Resident 129, 29,		longer in the facility) activity care				
					plans have been reviewed. They are		
	, ,				receiving appropriate leisure		
	Findings include	:			activities of interest to include		
	C				sensory stimulation. Care plans for		
	1. Resident #26'	s clinical record was			these residents have been updated		
	reviewed on 3/28	8/2012 at 9:30 A.M.			accordingly. II. The facility has		
	Resident #26 wa	s admitted on 5/18/10			reviewed all activity programs for		
	and had current of	diagnoses which included			residents who have been		
		a history of dementia,			determined as requiring assistance		
		er, hypothyroidism,			to get to activities and/or requiring		
	osteoarthritis, an	, 31			one on one visits. In addition, all		
	050000000000000000000000000000000000000	a corecporation.			residents will have their activity		
	A minimum data	assessment (MDS)			plan of care reviewed by the Activity Director.		
		licated Resident #26 was			Resident-Centered and specialized		
	· · · · · · · · · · · · · · · · · · ·	nted to time or place and			programs have been implemented		
		•			and the care plans have been		
	locomotion on a	ependant on staff for			updated for the residents.		
	locomotion on ai	na on the unit.			III. The systemic change		
	A1				will be that all residents who		
	A physician's act	•			require assistance to get to		
		n the current March 2012			activities and/or requiring one on		
	rewrite orders in	dicated Resident #26			one will receive programming/assistance a		
			1		p0. a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 8 of 78

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155196	B. WING			04/02/2012
e o o o				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	C		3525 E HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	could be up as tolerated.				minimum of 3 times per wk.	
					Residents who are able to attend	
	A current March	2012 care plan indicated			activities of choice will be	
	Resident #26 wo	ould self direct at least 1			encouraged and assisted to participate in leisure activities. The	10
	independent acti	vity daily to maintain her			Interdisciplinary Team will review	
	_	nd would participate in at			residents activity plan of care	
	1 ^	roups each week to her			during the quarterly review with	
	level of social in	*			the POA, if applicable, and will	
	level of social in	teraction.			make accommodations as needed	ı
	Ai-1i				to ensure needs of all residents a	re
	A social service note dated 4/28/2011				met regarding leisure interests ar	nd
	indicated Care plan meeting today with				needs of each resident. All	
		aughter and staff			Activities Associates will be	
	discussed health	status, diet, weight,			educated regarding the importan	ce
	mood, medicatio	ons and activity			of leisure interests designed to	
	involvement. Re	esident #26 feels			meet their assessed needs,	
	comfortable with	n her daily routine,			participation, and documentation	1
		d staff. Resident # 26			for all residents.	
	•	of the facility activities for			IV. Participation of the residents will be monitored utilizing	ing
	1	d post meal activities.			the Activity Participation Log and	
		•			the Activity 1:1 Log. The	
	Likes to rest in r	ner bed between meals.			Administrator or designee will	
					review the activity and	
		note dated 6/10/2011			participation log for 5 residents p	er
	indicated care	plan addressed Resident			unit weekly x 3 months, then 5	
	#26's impaired d	ecision making and			residents per unit every other we	ek
	sad/pained affec	t. Resident #26 is alert.			for 3 months, then 5 residents pe	
	She has problem	s with short/long term			unit monthly for the next 9 month	hs.
	1	nust anticipate her			Any issues or concerns will be	
		eeds would not be met.			addressed timely. The	
		supportive and visit at			Administrator or her designee wil	
	1	esident #26 exhibited sad			present the findings and reviews	
					during the monthly Quality Assurance Committee meeting ar	,d
		ed little interest in			frequency and duration of the	iu
	1	activities. She enjoyed			reviews will be adjusted as neede	d.
	1	r wheelchair rides with			. cr.ews will be aujusted as neede	
	family and 1:1 v	isits.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155196	B. WIN			04/02	/2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Completion date: April 29, 2012		
		lem listed for Resident					
		ted 8/5/2011 and on the					
	current March 20	112 care plan indicated					
	Resident #26 had	l a potential for low					
	activity involven	nent due to a decline in					
	her health care st	atus. She currently had					
	an interest in mu	sic, animals, hand					
	massages, and fa	mily visits. Resident #26					
	was to be encour	aged to participate in					
	animal assisted v	risits, evaluated for her					
	response to the p	lan of care, and update					
		eeded. Goals listed					
	-	nt #26 would participate					
		visit program twice each					
	week to provide						
	•	nterventions included:					
		ent #26 to participate in					
	animal assisted v	• •					
		her activity interest and					
	activity preference	•					
	activity preference						
	Resident # 26 ha	d a care plan problem					
		2/3/2011 and on a current					
		plan which indicated					
		ntinued to exhibit sad,					
	* ′	ied facial expressions as					
		rowed brows, tearfulness					
		tia, and depression.					
		ided Resident #26 would					
	_	nappiness as evidenced					
		aughing and conversing					
		g meals, activities and					
	activities of daily	living assistance on a					
					•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 10 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER		3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	daily basis. App this goal included #26 to become in activities and soor encourage her to concerns, fears, as she could draw or children, table munit, and observed of depression, teal loss of appetite as A current care placed 3/18/2012 indicates a sense of initiative videnced by her participating in his socializing with dementia and sack Resident #26 indicates of the community with others and preferred activities to so of the community with others and preferred activities and indicates and preferred activities activities and indicates and ind	roaches listed to reach d: encourage Resident evolved with physical cial interactions, verbalize feelings, etc., identify relationships on for example with staff, ates and friends on the efor signs and symptoms arfulness, withdrawal, and notify physician. an problem dated ted Resident #26 lacked ve/involvement as not showing interest in the favorite activities or others related to d mood. A goal listed for icated she would have socialize and feel a part by through interaction participating in her es throughout the day. Indeed allowing Resident options for example: wity in the morning or health status factors that				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 11 of 78

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIEI		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	wheelchair rides her to her favori pleasant convers (activities of dai meals, activities signs of isolation affect, non-complack of eye contal loneliness/reject. During observat P.M.: Resident was no music or resident's room. During observat 10:23 A.M. Resident was no delevision 1:20 P.M. she was lunch table with activity or music and 3:30 P.M. sl (no television or Observations on A.M.,10:06 A.M. Resident #26 was television or mu A.M. she was obin the dining room at 1:44 P.M. after actives were being activities of the dining room at 1:44 P.M. after actives were being activities and some activities and actives were being activities of the dining room at 1:44 P.M. after actives were being activities actives were being activities actives were seen activities activities actives were seen activities actives were seen activities activit	regular visits, take her on outside and accompany te activities, engage her in sation during ADLs ly living) assistance, and 1:1 visits, report in for example sad, dull municative, withdrawn, act, expressions of ion) to the doctor ion on 2/26/2012 at 2:16 # 26 was in bed. There television on in the ions on 2/27/2012: At as observed sitting at the her head down (no explaying). At 2:12 P.M. he was observed in bed in music playing). 3/28/2012: At 9:30 I., and 11:00 A.M., as observed in bed (no sic playing). At 11:50 observed up in a wheelchair of maining for lunch and er lunch. No music or ang provided during these P.M. Resident #26 was			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 12 of 78

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL	
111,12,12,111	or condition.	155196		LDING		04/02/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		with no television or					
	music playing.						
	Observations on	3/29/2012: Resident #					
	26 was observed	in bed without music or					
	television at 9:40) A.M., 10:41 A.M.,					
	11:15 A.M. and	3:00 P.M.					
	D: J + #0.6	h 1 2/20/12 - /					
		s observed on 3/30/12 at					
12:00 P.M. sitting at the dining room table with her head down no music							
playing, no one interacting with her, and no activity being provided.							
	no activity being	, provided.					
	During an interv	iew on 3/29/2012 at 3:54					
	P.M., The Activi	ty Director indicated,					
	Resident #26 wa	s only on a one to one					
	program twice a	week for not more than					
	twenty-five minu	ites at a time. Resident #					
	26 most often lik	ted for them to sit by her					
	bed and touch he	er hand. She liked gentle					
	_	nanicures, sensory type					
		rent texture balls that					
		her to squeeze. She liked					
		and she liked the animals					
	_	but only the smaller					
		l not participate in group					
		e of her cognitive status.					
		eel chair rides especially					
		at #26's daughter told					
		26 enjoyed classical and					
	"	usic and at times they					
	_	ic to her room during 1:1					
	visits. It was not	t provided in her room at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 13 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER		 3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
	out if her room in solarium. The A "she might be me group activity the activity director minutes of one of week is enough, goes by the state. During an intervery P.M. the Activity Resident #26 had activity for the procumentation of activities Resident including 1:1 act January, Februar Documentation of at this facility for also requested. On 3/30/2012 at February, and M calendars were recalled as indicated which included recalled and massages, maniculated sensory stimulation interest of Resident #26 reside	iew on 3/29/2012 at 3:54 7 Director was informed I not been observed at an ast four days. was requested of all int #26 had attended ivities for the months of y, and March 2012. of all activities provided r the same months were 9:30 A.M., the January, arch 2012 activity eviewed. These ed eighty-four activities music, church, hand ures, pet visits, and on (all assessed as ent #26) were offered at e A/B unit (where ided) and/or in the Resident #26 was				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 14 of 78

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIEI		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	dependent on sta and totally dependent on and off the un- facility provided Resident #26's 1	tho was assessed to be aff to anticipate her needs andent on staff for mobility nit did not attend any out of room activities.			
	Resident #26 wa 1:1 activities for the January 2012 record indicated	s provided five in room the month. Review of 2 activity attendance Resident #26 was			
	provided six in room 1:1 activities for the month. Review of the February 2012 activity record indicated Resident #26 was provided four 1:1 in room activities for the month. Review of the March 2012				
	Resident #26 wa 1:1 activities. During an interv	ce record indicated s provided two in room iew on 3/29/2012 at 3:00			
	Assistant) stated go to activities. here in the eveni	Certified Nursing , "We ask if they want to We usually do activities ng time around dinner. son will ask them if they ey are up they will			
	usually say yes.' when asked if th	CNA #9 indicated yes is included Resident #26.			
	reviewed on 10/2 Resident #37 wa	s clinical record was 28/2012 at 10:00 A.M s admitted on 1/13/2011 diagnoses which included			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 15 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02 /	ETED	
	PROVIDER OR SUPPLIER		• • • • • • • • • • • • • • • • • • • •	3525 E	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	•	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION
PREFIX TAG	but were not limit hip fracture, arth dementia, Alzheid depression, and a Resident #37's last assessment (Mindicated Resider assistance for beand required an amobility on and chad been assesse including reading magazines, lister around animals services and required an amobility on and chad been assesse including reading magazines, lister around animals services plan which it would participate sensory stimulations using her interest social interactions. Resident #37 enjexercise, going to programs and amonger appropriationit due to sexual	ited to a history of a left ritis, kyphoplasty, amer's disease, anxiety. Ist annual minimum data MDS) dated 1/19/2012 and #37 required extensive d mobility, did not walk, assistance of one for off the unit. Resident #37 d to prefer activities g books, newspapers or aing to music, being such as pets. If a current March 2012 and as pets.		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	DATE
	questioning due impairment. Ence participate in pro Evaluate her respand adjust as nee	to short term memory courage Resident #37 to grams on the unit. bonse to the plan of care ded. Provide a calendar ity programs. Transport					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 16 of 78

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155196	B. WIN	G		04/02/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	her to and from t	ne nair saion.					
	A care plan prob 8/3/2010 and on care plan indicate extensive assist value in the functional and control of the functional and the fun	lem originally dated the current March 2012 ed Resident #37 required with all activities of daily reased mobility, and ognitive impairments. It hocomotion to and and meals. Son on 3/26/2012 at 2:16 #37 was observed in bed. 3/27/2012: At 10:23 37 was observed in bed at the television (TV). At (Jerry Springer on TV) we was observed in bed. 3/28/2012 at 10:06 A.M. on TV, 11:50 A.M. sitting me table with no music, interaction being					
	1 ^	20 P.M. in bed eyes open n talking about "I Beat					
	My Kids". At 2:	30 P.M. in bed with Jerry					
	Springer on TV.						
	37 was observed A.M.,10:41 A.M on with subject V	3/29/2012: Resident # in bed at 9:40, 11:15 A.M. (talk show Whose My Baby's Daddy) udge Joe show on TV).					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 17 of 78

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIED		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	12:00 P.M. sittir table with no mu	as observed on 3/30/12 at an at the dining room usic playing, no one her, and no activity being			
	A.M. documenta the Activity Dire Resident #37 ha	riew on 4/2/2012 at 11:00 ation was requested from ector of all activities d attended including 1:1 months of January, Jarch 2012.			
	February, and M calendars were r calendars indica activities which visits, trivia, and assessed as inter offered at this fa (where Resident 37 who was asses	In 1:00 A.M., the January, larch 2012 activity reviewed. These ted at least forty-nine included music, pet a sensory stimulation (all rest of Resident #37) were ucility on the A/B unit #37 resided). Resident # ressed to be dependent on and off the unit did neility provided out of			
	attendance record was provided six for the month. If 2012 activity records	anuary 2012 activity and indicated Resident #37 as in room 1:1 activities Review of the February cord indicated Resident and four 1:1 in room			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 18 of 78

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIEI	R /ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	March 2012 acti	month. Review of the vity attendance record ent #26 was provided one vities.			
	P.M., CNA #9 (or stated, "We ask activities. We us in the evening to activity person we to and if they are	riew on 3/29/2012 at 3:00 certified nursing assistant if they want to go to sually do activities here me around dinner. The will ask them if they want e up they will usually say indicated yes when asked Resident #37.			
	reviewed on 3/2 Resident #129 w and had current but were not lim accident (stroke) aphasia, deafnes on hemodialysis hypertension, co disease, coronar	9's clinical record was 8/2012 at 10:30 A.M. vas admitted on 3/13/12 diagnoses which included ited to cerebrovascular with right hemiparesis, s, end stage renal disease, diabetes mellitus, bronary pulmonary y artery disease, atrial erlipidemia, and status oneumonia.			
	indicated Reside 1:1 activity prog stimulation due CVA (cerebral v	lan dated 3/30/2012 ent #129 had a need for a gram to provide sensory to a diagnoses of acute vascular accident-stroke) paresis and impaired			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 19 of 78

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		(X2) MUL' A. BUILDI B. WING		00	(X3) DATE : COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER		:	3525 E H	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	goal included Reparticipate in a 1 times a week to participate in a 1 times a week to participate in cluded: the plan of care a Resident #129's facility Resident scratch off lotter outdoors. A current care pl 3/26/2012 indicating impaired cognition making related to A goal included have the opportudecision for self Approaches included have the opportudecision on A.M. through at # 129 was out of Observations on #129 was observed 11:00 A.M., 115 P.M., 2:00 P.M. Observation on 3 A.M. through at	related to deafness. A sident #129 would :1 activity program three provide sensory socialization. Approaches evaluate his response to and adjust as needed. Prother reported to the #129 had an interest in sy tickets and being an problem dated the Resident #129 had on and daily decision of a history of a stroke. For Resident #129 was to mity to make simple throughout the day. Indeed allowing him time spond to information. 3/27/2012 from 9:00 pleast 3:00 P.M. Resident the building for dialysis. 3/28/2012: Resident ed in bed at 10:13 A.M. O A.M., 12:00 P.M. 1:34					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 20 of 78

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
	155196	A. BUILDING B. WING		04/02/2012
NAME OF BROWNER OF GUIDN II	n.		Γ ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIE			E HANNA AVE	
ALTENHEIM HEALTH & LI		INDIA	NAPOLIS, IN 46237	_
` '	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
Observations on #129 was obser 10:41 A.M., 11: During an interval. A.M. document the Activity Dir Resident #129 hactivities since in activities since in activities since in activities activities had been provide activities. 4. Resident #29 facility activities had been provide activities. 4. Resident #29 3/28/2012 at 11 Diagnoses listed but were not lind depression, neur arthropathy, per macular degene pacemaker, and Observation on indicated Resideroom in her who on. Observation on Observation on Observation on Indicated Resideroom in her who on.	a 3/30/2012: Resident wed in bed at 9:40 A.M., 15 A.M. and 3:00 P.M. Ariew on 4/2/2012 at 11:00 ation was requested from ector of all activities and attended including 1:1 his admission. 11:00 A.M., Resident attendance records were a month of March 2012. and not attended any since his admission or ed with 1:1 in room In for resident #29 included hited to; hypertension, ropathy, abnormal posture, ipheral vascular disease, ration, urine retention,	TAG	DEFICIENCY)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 21 of 78

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/02 /	ETED	
	PROVIDER OR SUPPLIER		p. wind	3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	!	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	room in her recli on.	ner with the television					
	indicated an over indicating that a was being started 4/2/2012 from 10 indicated that the room sitting in he the television on no employee into at this time. Interview on 4/2, LPN #14 indicate mainly just one of Today was the firesident said, "the doesn't talk at all her call light on a ask her what she and she won't resappear to need at Director goes in with her. She use often has a book know if she's act she may be able	chead announcement special pet visit activity d. Observation on 0:00 a.m. until 10:22 a.m. eresident was in her er recliner awake with to a morning talk show, eractions were observed cheat details and you," she usually and you'll go in there and needs, why she put it on spond back verbally or nything. The Activity and does one on ones ad to enjoy reading, she in front of her but I don't ually reading now or not, to. Its hard to tell because and she watches the in her room."					
	A care plan dated 11/16/2011 indicated, "Focus: Resident #29 has a potential for						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 22 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155196		LDING	00	04/02/	
		133190	B. WIN			04/02/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	social isolation a	nd low activity					
	involvement due	to isolating self in room					
	and a preference for her own company.						
	Goal: Resident #	29 will participate in at					
	least one group p	orogram of interest					
	(animal assisted	visits, no bake cooking,					
	cards, and devoti	ions) each week to					
	provide opportur	nities for socialization					
	and decrease her	risk of social isolation.					
	Approach: assist	Resident #29 in making					
choices about activity preferences.							
	Approach: encourage family support						
	during activity p	articipation. Approach:					
	encourage #29 to	participate in pre-meal					
	activity program	s on the unit. Approach:					
	encourage Resid	ent #29 to participate in					
	the religious pro	grams (inspiration and					
	spirit gathering)	on the unit. Approach:					
	invite Resident #	29 to special programs of					
		ch: provide a calendar of					
	monthly activities	es program in room."					
		1.7/6/0010: 1: 1					
		d 7/6/2010 indicated,					
		ent #29 has impaired					
	1 -	aking related to dementia.					
		urage small group					
		ulate intellect. Likes					
	religious group o	on C wing."					
	An activity log for	or Resident #29 for the					
	1	2012 had 'A' meaning					
		on for TV/movies for the					
	1st through the 5th of the month. The rest						
	of the activity lo						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 23 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER			3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	2012 indicated the highlighted as unand chair aerobic refused catholic refused and animal refused on the Activity Director a.m. this morning She also indicate had a decline in but she is unsure coincided with a Activity Director Resident #29 does visits. 5. The clinical refused catholic refused and refused refused and refused refu	or the month of April nat the resident was havailable for dice games, as for April 1st. She mass, bunco, worship and fit for April 1st. On ent #29 refused chair mal visit. 2012 at 11:40 a.m. with ctor indicated Resident of the animal visit at 10:00 as because she refused. In the area definitely mer activity participation, as to why or if this health decline. The realso indicated that esn't receive one on one eccord for Resident #6 a3/28/12 at 9:30 a.m. Assion MDS (Minimum ment indicated it was very sident #6 to go outside reas good and to agious events. The MDS area for activities was are plan was created. No an could be found in the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 24 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPLETED
		155196	B. WING			04/02/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	IN	IDIAN/	APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)	DATE
	On 3/29/12 at 10					
		ver the loudspeaker				
		Study would be held in				
		0:30 on 3/29/12. At this				
		6 was observed lying in				
	bed in his room.	No one was observed to				
	inform the reside	ent of the activity or				
	encourage him to) go.				
	During interview	with the Activity				
	Director on 3/30	/12 at 2:53 p.m., she				
	indicated Reside	nt #6's care plan was on				
	her "to do" list.	She indicated he mostly				
	preferred his own	n company and religious				
	_	atched television				
	ı ^ ~	s assessment also				
		yed classical music. She				
	ľ	ad not played or offered to				
		il music for him. He had				
	not done anythin					
	not done anythin	5 oatside officer.				
	Review of the M	arch, 2012 activity				
		for Resident #6 was				
	completely blank					
	completely blank	λ.				
	During another :	ntarviany at 10.10 a m. an				
		nterview at 10:10 a.m. on				
		Activity Director, she				
		y independent activity				
	_	evision and that he did				
		y religious activities, go				
	· · · · · · · · · · · · · · · · · · ·	to any classical music				
		of 3/26/12. He just				
	watched television	on.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 25 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 04/02	ETED
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO HANNA AVE	DDE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3.1-33(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 26 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED		
		155196	A. BUILDING B. WING		04/02/2012
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	STREET 3525	FADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0253 SS=E	SERVICES The facility must maintenance set a sanitary, order Based on observation for 5 of (Rooms 1073, 1 and 1097) Findings included Observations or 3/27/2012 at 3:0 P.M., 3/29/2012 at 9:30 A.M., ar revealed the following the bed with the set of the s	a 3/26/2012 at 2:30 P.M., 20 P.M., 3/28/2012 at 3:00 at 9:30 A.M., 3/30/2012 at 1/2/2012 at 9:30 A.M. dowing: There were several areas where the wall paper was all. Behind both beds the acraped off the base 1 paper had dark stains in t areas. The equipment had several sharp edges and was	F0253	F253-483.15 (h) (2) HOUSEKEEPING & MAINTENANCE SERVICES I. The areas of concerns identified in rooms # 1073, # 1075, # 1079, # 1095, # 1097, and # 1096 were reviewed and addressed timely. # 1073- Accordion door was removed, wall paper and covering were removed, wall was painted on 04-17-12. #1075- Base boards were removed, the room will be repainted, and the heating and air conditioning unit will be replaced. #1079- Accordion door was removed. The wall paper will be removed by the maintenance department and the room will be repainted. In addition, the black window seal strip has been removed. #1095 – Heater and air unit has been cleaned. # 1097-Doo frame will be repainted and all holes will be patched appropriately. The floor trim will be replaced and the heating and ai unit will be replaced. #1096- The holes in the bathroom will be repainted. II. The areas of concert identified will be inspected	r

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 27 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155196	B. WIN			04/02/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			3525 E	HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
			1		,	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
TAG		<u> </u>		IAU		DATE
		bathroom had six			throughout the community.	
		stains. Above the toilet			III. The systemic change will include: that the maintenance	
	there were brown	n streaked stains. The			department will monitor all facility	
	black window se	al strip was hanging			bathrooms and resident rooms. The	
	down from the w	vindow.			Administrator of designee will	
	4. Room 1095 -	There was dirt on			monitor the maintenance/cleaning	
		hich covered a three feet			audits weekly x 4 months, then	
	of area.	mon covered a timee feet			monthly thereafter. Rooms will be	
		The deep frame 1-1			routinely inspected monthly.	
		The door frame needed			IV. The results of these	
	• `	d frame removed leaving			environmental rounds will be	
		red and scraped). There			reviewed and discussed at the	
	were five holes in	n the bathroom wall with			Quality Assurance Committee	
	blue molly bolts	showing. The floor trim			monthly and frequency and	
	was missing on e	entryway from room to			duration of the reviews will be	
	_	ir/heat unit was scraped			adjusted as needed.	
		There was a hole in east				
		poard measuring 2 x 2"				
	1	· ·			Completion date: April 29, 2012	
	on east wall by b	aseboard.				
		he bathroom had five				
	holes with expos	ed blue molly bolts, The				
	side of the bathro	oom wall was scuffed and				
	needed painted.	There were marks on the				
	•	f room where it needed				
		e wall also had marks of				
	•	nd three nail holes.				
	a Diack Illanci all	d thee han holes.				
	2.1.10(0(5)					
	3.1-19(f)(5)					
			1			ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 28 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155196	B. WING 04/02/2			2012	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
AI TENILI		INC COMMUNITY			HANNA AVE		
ALTENTI	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	483.20(d), 483.2 DEVELOP COM	0(k)(1) PREHENSIVE CARE					
	PLANS						
	•	se the results of the					
		evelop, review and revise the					
	resident's compr	ehensive plan of care.					
		develop a comprehensive					
	•	ch resident that includes					
	-	ctives and timetables to smedical, nursing, and					
		hosocial needs that are					
		comprehensive assessment.					
		•					
	•	ust describe the services that					
		ed to attain or maintain the					
	_	st practicable physical, chosocial well-being as					
		483.25; and any services					
		wise be required under					
		not provided due to the					
		se of rights under §483.10,					
		nt to refuse treatment under					
	§483.10(b)(4).						
		ew and record review, the	F027	19	F279-483.20 (d). 483.20 (k)		04/29/2012
	facility failed to	ensure an activities care			(1)		
	plan was created	after triggered on the			COMPREHENSIVE CARE		
	MDS (Minimum	Data Set) assessment			PLANS		
	and failed to have				I. Resident #6 is		
		re plan for 2 of 35					
					no longer in the facility. The		
		ed for appropriate care			care plan of		
	plans. (Resident	t #6 and 48).	1		Resident #48 was reviewed		
			1		and updated as necessary.		
	Findings include	:			II. All residents		
					that have an activity care		
	1. The clinical re	ecord for Resident #6			plan triggered by the MDS		
		3/28/12 at 9:30 a.m.			and residents with a		
	was it viewed oil	5/20/12 at 7.30 a.iii.					
					restorative program have		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 29 of 78

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIER HEIM HEALTH & LIVING COMMUNITY	STREET A 3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The 3/7/12 Admission MDS indicated the		been identified and will have	
	care area for activities was triggered and a care plan was created. No activities care		care plans reviewed for	
	plan could be found in the clinical record.		completion. III. Systemic	
	prairie e data de rouna in une enimear recora.		changes include the	
	During interview with the Activity		following:	
	Director on 3/30/12 at 2:53 p.m., she		Residents requiring a	
	indicated Resident #6's activity care plan		new restorative program wil	I
	was on her "to do" list.		be discussed at the daily	
			(Monday through Friday)	
			interdisciplinary clinical	
			meeting, which includes	
			therapy and the restorative	
			nurse. The Restorative Nurse	e
			will then complete the	
			Restorative Nursing Program	
			and the care plan. The MDS coordinator	
			will review the triggered	
			areas from the MDS for	
			completion of care plans	
			triggered. She will provide a	n
			audit of the activity care plar	
			completion to the	
			Administrator.	
			· The DON/designee wil	I
			meet with the restorative	
			nurse to review residents on	
			a restorative program for	
			care plan completion.	
			Education was provided to	
			the Restorative Nurse	
			regarding completion of a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 30 of 78

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/02/2012
ALTENHI	ROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
IAU	ACCURATION ON ESC IDENTIF TING INFORMATION)	IAG	restorative care plan with a restorative programs. Education was provided to the Activity Director and Activity staff regarding time completion of care plans when triggered by the MDS IV. The Activity Director will provide a care plan review of 5 residents punit once every other week for completion of activity care plans triggered by the MDS for 12 weeks then once a month for 9 months totaling 12 months of auditing. The Director of Nursing or designee will review 3 residents per unit each week requiring a restorative program for completion of care plan for 4 weeks, then resident per unit each week for 4 weeks, then 3 resident monthly for a total of 12 months of monitoring. The results of the reviews will be discussed at the monthly facility Quality Assurance meetings and frequency and duration of the reviews	ely ely ele ele ele ele te te te te te
			will be adjusted as needed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 31 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPL 04/02 /	ETED
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	reviewed on 3/29 Resident #48 rec Therapy (OT) fr consisting of the activities and sel further document therapy could be Diagnoses for Reare not limited to During an observa. Resident #4 room from exercinterviewed at the this resident is serestorative aid an improving due to During an interviewed at the this resident is serestorative aid an improving due to During an interviewed at that Remaking progress was referred to a 2/10/12. During an interviewed at the making progress was referred to a 2/10/12.	eived Occupational om 1/19/12 to 2/10/12 rapeutic exercises, f care training but no tation of OT patient found. esident #48 include but			Completion date : April 29, 2012		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 32 of 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/02/2012
ALTENH	PROVIDER OR SUPPLIER HEIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODI HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	Program on 2/14/12. She also indicated that she had been off work for a while and could not find in the file where a care plan for the Restorative Program had been written for this resident. 3.1-35(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 33 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A DIVIDING 00 COMPLETED			
ANDILAN	or connection	155196	A. BUILDING		04/02/2012	
		1.00.100	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0 1/0 2/20 12	
NAME OF F	PROVIDER OR SUPPLIE	R		HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0280 SS=D	CARE-REVISE The resident has incompetent or or incapacitated ur participate in plate changes in care A comprehensive developed within of the comprehensive an interdiscipattending physic responsibility for appropriate staff by the resident's	TICIPATE PLANNING CP s the right, unless adjudged otherwise found to be ander the laws of the State, to anning care and treatment or				
	the resident's fa representative; a revised by a tea each assessme Based on intervi	mily or the resident's legal and periodically reviewed and m of qualified persons after nt. ew, observation, and e facility failed to revise	F0280	F280-483.20 (d) (3), 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE –REVISE CARE PLAN	04/29/2012	
	-	activities and toileting for 3 of 35 residents		I. Resident #60 no		
		re plans (Resident 60, 29,		longer resides in the facility; The		
	and 37).	o planto (recondent 00, 27,		care plans for residents #29 and # 37 were updated.		
	Findings include); ;		II. All residents with updated assessments, over the last 3 months, for activities and	:	
	1. Resident #60'	s record was reviewed on		toileting have been identified and the care plan has been revised		
	3/28/2012 at 1:3	0 p.m. Diagnoses		and/or reviewed related to the		
	included but we	re not limited to; muscle		updated assessment.		
	weakness, diffic	ulty walking, anxiety,		III. Systemic changes		
	restless leg synd	rome, dementia, renal		include:		
	(kidney) failure,	and depressive disorder.		An interdisciplinary		
	· · · · · · · · · · · · · · · · · · ·	•		care plan meeting will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 34 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155196	B. WIN			04/02/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
A1 TEAU !!		TNO COMMUNITY			HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG				TAG	· · · · · · · · · · · · · · · · · · ·	DATE
		ess note dated 2/4/12 at eed Resident #60 had a			held after the resident's	
		om. A Fall event form			assessment period, at which	
					time assessments are	
		urses note with the same			completed, to review the	
		ted indicated, "Location			care plan for updates related	
		oom-bathroom. Resident			to the assessment. Emphasis	;
	_	ot up to take himself to			will be on the activity and	
		as the fall witnessed?			toileting assessment and care	
					plan.	
		the fall? Socks with skid			Education will be provided to)
	• 1	ent exhibit or complain of			the Activity Director	
	•	e fall? If so, describe			regarding revising the care	
	· ·	esident stated that his			plan after assessment and	
	right hip hurt. Ra				the systemic change.	
	•	ense. Body observation:			Education will be provided to	,
		was right hip. Note any			licensed nurses regarding	
		d, extremities, or trunk:			revising the care plan for	
		Range of Motion: ROM			toileting after an assessment	
) painful/limited in lower			and the systemic change.	
		ent would not let nurse				
		nis right lower extremity.			IV. The Activity	
	Positioning of ex				Director will provide a care	
		ity/shortening of right			plan review of 5 residents pe	r
	1	Immediate first aid			unit once every other week	-
		no first aid needed.			for completion of activity	
	Resident was ass				care plans after completion	
	_	bduction of right lower			of an assessment for 12	
		ined to the aides and the			weeks then once a month for	
	resident not to m	•				
	Interventions: in				9 months totaling 12 months	
		re in use at the time of			of auditing.	
	me ian: non-skic	I footwear, bed alarm."			The Director of Nursing or	
	A comparate :: 4 - 4	J 10/01/0011 : J: 1			designee will review 3	
	A care plan dated	d, 12/21/2011, indicated			residents each week after	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 35 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155196	B. WIN	NG		04/02/2012
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE	
A 1 TENU 1		(INIC COMMANDATIV			HANNA AVE	
		/ING COMMUNITY		<u> </u>	APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		ent at risk for falling		IAG		DATE
		lementia, weakness due to			completion of a toileting	
	· · · · · · · · · · · · · · · · · · ·	ration, episodes of urinary			assessment for an update of	
	^	d decline in functional			the toileting care plan for 4	
		sident will remain free			weeks, then 1 resident each	
		proach: updated on			week for 4 weeks, then 3	
		leave the rolling walker in			residents monthly for a total	
	site." (sic)	icuve the forming wanter in			of 12 months of monitoring.	
	Site. (Sie)				The results of the reviews wil	
	2 Resident #29'	s record was reviewed on			be discussed at the monthly	
	3/28/2012 at 11:				facility Quality Assurance	
		for resident #29 included			meetings and frequency and	
	_	ited to; hypertension,			duration of the reviews will	
		opathy, abnormal posture,			be adjusted as needed.	
	•	ipheral vascular disease,				
		ration, urine retention,			Completion data: April 20, 2012	
	pacemaker, and				Completion date: April 29, 2012	
	F ,					
	Observation on	3/27/2012 at 11:46 a.m.				
	indicated Reside	ent #29 was sitting in her				
	room in her whe	elchair with the television				
	on.					
	Observation on 3	3/30/2012 at 1:00 p.m.				
	indicated Reside	ent #29 was sitting in her				
	room in her recl	iner with the television				
	on.					
	Observation on	4/2/2012 at 10:00 a.m.				
	indicated an ove	rhead announcement				
	indicating that a	special pet visit activity				
	was being starte	d. Observation on				
	4/2/2012 from 1	0:00 a.m. until 10:22 a.m.				
	indicated that th	e resident was in her				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 36 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS			COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155196	B. WIN			04/02/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
A1 TENII I					HANNA AVE		
	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		<u> </u>	+	TAG	DEFICIENCE!		DATE
	_	er recliner awake with					
	the television on	to a morning talk show.					
	I	/2012 - 4 10 10 14					
		/2012 at 10:18 a.m. with					
	_	er indicated, "Resident					
		just one on ones for					
		was the first time in a					
		ident said, "thank you,"					
	_	n't talk at all. Sometimes					
	she puts her call light on and you'll go in						
	there and ask her what she needs, why she						
	put it on and she won't respond back						
	verbally or appear to need anything. The						
		goes in and does one on					
		ne used to enjoy reading,					
		ook in front of her but I					
		e's actually reading now					
	-	be able to. Its hard to tell					
		ly speaks. She watches					
	the cooking chan	inel in her room."					
	-	d 11/16/2011 indicated,					
		t #29 has a potential for					
	social isolation a	nd low activity					
	involvement due	to isolating self in room					
	and a preference	for her own company.					
	Goal: Resident #	29 will participate in at					
	• • •	program of interest					
	(animal assisted	visits, no bake cooking,					
	cards, and devoti	ions) each week to					
	provide opportur	nities for socialization					
	and decrease her	risk of social isolation.					
İ	Approach: assist	Resident #29 in making					
	choices about ac	tivity preferences.					
					l		<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 37 of 78

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155196	B. WIN	G		04/02/2	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
AI TENIH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
			1		AI OLIO, IIV 40201		975)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Approach: encou	urage family support					
		participation. Approach:					
	encourage #29 to	o participate in pre-meal					
	activity program	s on the unit. Approach:					
	encourage Resident #29 to participate in						
	the religious programs (inspiration and						
	spirit gathering) on the unit. Approach:						
	invite Resident #29 to special programs of						
	interest. Approach: provide a calendar of						
	monthly activities program in room."						
	A care plan dated 7/6/2010 indicated,						
		ent #29 has impaired					
	1 -	aking related to dementia.					
		urage small group					
	1	nulate intellect. Likes					
	religious group o	on C wing."					
	Δn activity log f	For Resident #29 for the					
	1	2012 had 'A' meaning					
		ion for TV/movies for the					
		5th of the month. The rest					
		g was blank. An activity					
	1	h of April 2012 indicated					
		was highlighted as					
		lice games, and chair					
		il 1st. She refused					
	_	unco, worship service,					
	and sit and fit for April 1st. On April 2nd,						
	Resident #29 refused chair aerobics and						
	animal visit.						
l		/0.010					
		/2012 at 11:40 a.m. with					
	the Activity Dire	ector indicated Resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 38 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02 /	ETED
	PROVIDER OR SUPPLIER		p. wiii	3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	a.m. this morning The Activity Dir Resident #29 doe visits. She also in definitely had a c participation, but or if this coincide 3. Resident #37' reviewed on 10/2 Resident #37 wa and had current of but were not limit hip fracture, arth dementia, Alzhei depression, and a Resident #37's la set assessment (N indicated Reside assistance for be and required an a mobility on and of had been assesse including reading magazines, lister around animals s	st annual minimum data MDS) dated 1/19/2012 nt #37 required extensive d mobility, did not walk, assistance of one for off the unit. Resident #37 d to prefer activities g books, newspapers or hing to music, and being uch as pets.					
	care plan which is would participate sensory stimulations using her interest	If a current March 2012 indicated Resident #37 in in it is in 1:1 programs for on to decrease anxiety it in animals, music, and its. Approaches included:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 39 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDIN		nstruction 00	(X3) DATE (COMPL 04/02/	ETED	
			B. WING ST	REET A	DDRESS, CITY, STATE, ZIP CODE	1 • 2	
NAME OF P	PROVIDER OR SUPPLIER				HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY	IN	IDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ED TO THE APPROPRIATE	
		oyed musical programs,					
	exercise, going to	o the hair salon, spiritual					
		imal visits. She is no					
	longer appropriate for programs off the						
	unit due to sexually inappropriate						
	· ·	petitive calling out-					
	questioning due to short term memory						
	-	courage Resident #37 to ograms on the unit.					
		C					
	Evaluate her response to the plan of care and adjust as needed. Provide a calendar						
	,	ity programs. Transport					
	her to and from t						
	A care plan prob	lem originally dated					
	8/3/2010 and on	the current March 2012					
	care plan indicate	ed Resident #37 required					
		with all activities of daily					
		reased mobility, and					
		ognitive impairments.					
		th locomotion to and					
	from activities ar	nd meals.					
	A social service	note dated 3/15/2012					
		nt #37 was reviewed					
		r management meeting					
	_	behaviors from 3/1/2012.					
	A social service	note dated 3/1/2012					
	indicated no	evidence of behaviors					
		A social service note					
		indicated no evidence					
		ed between 2/9/2012 and					
	2/16/2012						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 40 of 78

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155196	B. WIN	G		04/02/2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			3525 E	HANNA AVE	
	EIM HEALTH & LIV				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
		3/26/2012 at 2:16 P.M.:				
	Resident #37 wa	s observed in bed.				
	Observations on	3/27/2012: At 10:23				
		37 was observed in bed				
		n the television (TV). At				
	1	` '				
	11:32, 2:12 P.M. (Jerry Springer on TV)					
	and 3:30 P.M. she was observed in bed. Observations on 3/28/2012 at 10:06 A.M. (Maury Povich on TV, 11:50 A.M. sitting at the dining room table with no music,					
	activity, or staff					
	1 2	20 P.M. in bed eyes open				
	•	• •				
		n talking about "I Beat				
	_	30 P.M. in bed with Jerry				
	Springer on TV.					
	Observations on	3/29/2012: Resident #				
	37 was observed	in bed at 9:40				
	A.M10:41 A.M	., 11:15 A.M. (talk show				
	· · · · · · · · · · · · · · · · · · ·	Whose My Baby's Daddy)				
	1	udge Joe show on TV).				
	Resident #37 wa	s observed on 3/30/12 at				
		g at the dining room				
		sic playing, no one				
		her, and no activity being				
	provided.	nor, and no activity being				
	provided.					
	During an interv	iew on 4/2/2012 at 11:00				
		tion was requested from				
		ector of all activities				
	1	d attended including 1:1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 41 of 78

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURV COMPLETED 04/02/2012)
		155196	B. WIN			04/02/201/	۷
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	/ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	activities for the	months of January,					
	February, and M	Iarch 2012.					
	On 4/2/2012 at 11:00 A.M., the January,						
		Iarch 2012 activity					
	calendars were r	reviewed. These					
		ted at least forty-nine					
		included music, pet					
	visits, trivia, and sensory stimulation (all assessed as interest of Resident #37) were offered at this facility on the A/B unit (where Resident #37 resided). Resident #						
		essed to be dependent on					
	_	y on and off the unit did					
	1	acility provided out of					
	room activities.						
	_	view on 4/2/2012 at 11:00					
	A.M. documenta	ation was requested from					
	_	ector of all activities					
		d attended including 1:1					
		months of January,					
	February, and M	Iarch 2012.					
	Review of the Ja	anuary 2012 activity					
		d indicated Resident #37					
	was provided six	x in room 1:1 activities					
	_	Review of the February					
		cord indicated Resident					
	1	ed four 1:1 activities for					
	•	iew of the March 2012					
		ace record indicated					
	1	as provided one in room					
		esident #37 had not been					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 42 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	00	COMPLETED 04/02/2012	
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	352	EET ADDRESS, CITY, STATE, ZIP CODE 25 E HANNA AVE DIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIO		CROSS-REFERENCED TO THE APPROPE	(X5) COMPLETION DATE	
	taken to out of room activities on or off the unit during this time.				
	During an interview on 3/29/2012 at 3:00 P.M., CNA #9 (certified nursing assistant stated, "We ask if they want to go to activities. We usually do activities here in the evening time around dinner. The activity person will ask them if they want to and if they are up they will usually say yes." CNA #9 indicated yes when asked if this included Resident #37 Resident #37 did not have a current revised plan of care regarding the lack of behaviors which had previously restricted her from leaving the unit for activities. 3.1-35(d)(2)(B)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 43 of 78

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012	
	PROVIDER OR SUPPLIER		STREE 3525	T ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F0282 SS=E	CARE PLAN The services profacility must be pin accordance win plan of care. Based interview, review, the facility physician's order reviewed for physician's order reviewed for service wed fo	O's clinical record was 8/2012 at 10:30 A.M. as admitted on 3/13/12 diagnoses which included ted to cerebrovascular with right hemiparesis, s, end stage renal disease diabetes mellitus, ronary pulmonary artery disease, atrial rlipidemia, and status	F0282	F282-483.20 (k) (3) (ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I. Resident #12 no longer resides at the facility. The Activity care plans for Resident #26 and #37 were update to reflect current activity plans an services are being provided as outlined in the plan of care. II. All residents with orders for support equipment have been identified and the physician's orders are being followed. All residents have current care plans regarding activitie and the services are being provided as outlined in the plan of care. III. Systemic changes include: All residents with an order for support equipment will have the equipment	ed d	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155196	B. WIN	G		04/02/2	2012
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	wheel chair.				listed on the C.N.A.		
	D!	4/2/2012 - 4			assignment sheets. The		
	_	vation on 4/2/2012 at			C.N.A. assignment sheets are		
		ident #129 was observed			updated daily (Monday		
		eel chair without the lap			through Friday) at the clinical		
	1 -	the wheel chair. During			meeting; and as needed by		
	an interview at this time, LPN (licensed practical purse) #13 stated. "We have				the charge nurses during		
	practical nurse) #13 stated, "We have				non-business hours. The		
	been looking for the tray." CNA				Charge Nurse and		
	(certified nursing assistant) #12 indicated				Administrative Nursing staff		
	they had been looking for it all day. The				will make rounds daily for		
	1 -	ssing all weekend.			compliance with the ordered		
	During an interv				support equipment being		
	_	erapist #11 stated,			utilized.		
		in chair he should have			The Activity Director or	.	
	the tray on. He l				designee will coordinate		
		ne right. That is why he			scheduled group activities on		
	1	eep his arm in a good			the activity calendar with the		
	position so it wil	I not separate."			resident's individual plan of		
					care and documented		
	_	iew on 4/2/2012 at 10:20			interests to meet the		
	ĺ	‡129's sister-in-law			resident's individual interests		
		nt #129 did not have the			and needs. One on one	'	
	*	fell two days earlier and			activities will be based on the		
		emergency room for			individual interests of the	-	
	stitches.						
					resident as well as providing		
	_	iew on 4/2/2012 at 3:00			materials or programming for		
	· ·	(director of nursing			self directed activities of		
		I not know the tray had			interest.		
	_	weekend. Resident #129					
	_	o correctly position his			Education will be provided to		
		er the tray was not used to			nursing staff regarding		
	keep him from fa	alling out of the chair.			updating and utilizing the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
		155196	B. WIN			04/02/2012
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			HANNA AVE	
AI TENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
	-					77.0
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	
	2 D				C.N.A. assignment sheets and	l e
		's clinical record was			completing rounds daily for	
		8/2012 at 9:30 A.M.			compliance with the ordered	
		s admitted on 5/18/10			support equipment being	
		diagnoses which included			utilized. Education also will	
	but not limited to a history of dementia,				include assisting with	
	high blood presser, hypothyroidism,				transporting residents to	
	osteoarthritis, and osteoporosis. A minimum data assessment (MDS) dated 3/9/12, indicated Resident #26 was alert but not oriented to time or place and she was totally dependant on staff for				activities of their choice as	
					directed by the Activities	
					Director.	
					Education will be provided to	
					the Activities Director	
					regarding the systemic	
	locomotion on a	nd off the unit.			change and providing	
					activities that meet the need	.
	A physician's act	tivity order dated				·
	5/20/2010 and or	n the current March			of the residents per the plan of care.	
	rewrite orders in	dicated Resident #26				
	could be up as to	olerated.			The education will include	
					information on the choice of	
	A current March	2012 care plan indicated			TV programs the residents	
	Resident #26 wo	ould self direct at least 1			are watching to ensure the	
	independent acti	vity daily to maintain her			program are appropriate and	
	_	d would participate in at			meet the interests of the	
	least 2 activity g	roups each week to her			residents as documented on	
	level of social in	•			the care plans or voiced by	
					the residents/POA.	
	A social service	note dated 4/28/2011				
	indicated Ca	are plan meeting today			IV. The Unit	
		26's daughter and staff			Manager or designee will	
		status, diet, weight,			complete daily rounds	
	mood, medicatio				(Monday through Friday) on	
	involvement. Re	-			the unit to monitor for	
		her daily routine,			compliance with the ordered	
		,			Somphanice with the ordered	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155196	B. WIN			04/02/2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
AI TENHI	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	, ii ozio, iii iozoi	(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	environment, and	d staff. Resident # 26			support equipment being	
	attending some of	of the facility activities for			utilized per the physician	
	example: pre an	d post meal activities.			orders. Any concerns will be	
	Likes to rest in h	er bed between meals.			addressed.	
					The Administrator or	
		note dated 6/10/2011			designee will observe the	
	indicated car	-			activity for residents who are	e
	Resident #26's impaired decision making and sad/pained affect. Resident #26 is alert. She has problems with short/long term memory. Staff must anticipate her needs or her needs would not be met.				room-confined per unit for 1x	(
					per for 4 weeks, then 1 x per	
					week every other for 4	
					weeks, then monthly for a	
					total of 12 months of	
	<u>-</u>	supportive and visit at			auditing/observation. The	
	,	esident #26 exhibited sad			Administrator or her	
		ed little interest in			designee will review the	
		ctivities. She enjoyed wheelchair rides with			activity and participation log	
	family and 1:1 vi				related to activities provided	
	lanning and 1.1 vi	15115.			that meet the needs of the	
	A care plan prob	lem listed for Resident			residents per the plan of care	
		ated 8/5/2011 and on the			for 5 residents per unit 1 x	
		012 care plan indicated			other week x 3 months for	
		d a potential for low			the next 12 weeks and then	
		nent due to a decline in			will review monthly for the	
		atus. She currently had			next 9 months. Any issues or	
		sic, animals, hand			concerns will be addressed	
	massages, and fa	mily visits. Resident #26			timely.	
	was to be encour	aged to participate in				
	animal assisted v	risits, evaluated for her			The results of the reviews wil	ı
		lan of care, and update			be discussed at the monthly	
	•	eeded. Goals listed			facility Quality Assurance	
		nt #26 would participate			meetings and frequency and	
	1	visit program twice each			duration of the reviews will	
	week to provide	opportunities for			be adjusted as needed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 47 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	LDING	onstruction 00	(X3) DATE : COMPL 04/02/	ETED
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE	•	
ALIENH	EIM HEALTH & LIV	ING COMMUNITY	INDIAN	APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	socialization's. Ir encourage Reside animal assisted v massages, assess activity preference. Resident # 26 had originally dated 2 March 2012 care Resident #26 corpained, and worr evidenced by fur related to dement Goals listed incluexhibit signs of his by her smiling, la pleasantly during activities of daily daily basis. App this goal included #26 to become in activities and sociencourage her to concerns, fears, each she could draw of children, table m	terventions included: ent #26 to participate in isits, offer hand her activity interest and ees. d a care plan problem 2/3/2011 and on a current plan which indicated attinued to exhibit sad, ied facial expressions as rowed brows, tearfulness tia, and depression. aded Resident #26 would happiness as evidenced aughing and conversing ty meals, activities and a living assistance on a roaches listed to reach d: encourage Resident avolved with physical		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	
	of depression, tea	nrfulness, withdrawal, nd notify physician.				
	3/18/2012 indica a sense of initiati	an problem dated ted Resident #26 lacked ve/involvement as not showing interest in				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 48 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155196	B. WIN	G		04/02/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
A1 TEAU !!		INIO COMMUNITY			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ner favorite activities or					
	socializing with						
	dementia and sad mood. A goal listed for						
		icated she would have					
		socialize and feel a part					
		y through interaction					
	•	participating in her					
	•	es throughout the day.					
	Interventions inc	luded allowing Resident					
	# 26 to choose of	ptions for example:					
	attending an activity in the morning or						
	afternoon, assess	health status factors that					
	may inhibit socia	al involvement,					
	encourage her to	attend small group					
	activities such as	: prayer and devotion on					
	the a/b wing, mo	vement therapy, and					
	special meals, en	courage her to verbalize					
	her feelings and	fears, encourage family					
	_	regular visits, take her on					
		outside and accompany					
	her to her favorit	e activities, engage her in					
		ation during ADLs					
	•	y living) assistance,					
	*	and 1:1 visits, report					
	· ·	for example sad, dull					
	_	nunicative, withdrawn,					
	· ·	ect, expressions of					
	loneliness/rejecti						
	101101111035/1010011	on, to the doctor					
	Observations on	2/26/2012 at 2:16 P.M.:					
		bed (no music or					
		oca (no music oi					
	television).						
	Observations on	2/27/2012: At 10:23					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 49 of 78

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155196	B. WING		04/02/2012
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER	N.	3525	E HANNA AVE	
		ING COMMUNITY		NAPOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION DATE
TAG		26 was observed in bed	IAG		DATE
	`	music playing). At 1:20			
		served sitting at the lunch			
	table with her head down (no activity or				
	1 2 0	At 2:12 P.M. and 3:30			
	P.M. she was observed in bed (no				
	television or music playing).				
	Observations on 3/28/2012: At 9:30				
	A.M.,10:06 A.M	I., and 11:00 A.M.,			
	Resident #26 wa	as observed in bed (no			
	television or music playing). At 11:50				
	A.M. she was ob	oserved up in a wheelchair			
		om waiting for lunch and			
		er lunch. No music or			
		ng provided during these			
		P.M. Resident #26 was			
		with no television or			
	music playing.	with no television of			
	music playing.				
	Observations on	3/29/2012: Resident #			
	26 was observed	I in bed without music or			
	television at 9:40	0 A.M., 10:41 A.M.,			
	11:15 A.M. and				
	Resident #26 wa	s observed on 3/30/12 at			
	12:00 P.M. sittir	ng at the dining room			
	table with her he	ead down no music			
	playing, no one	interacting with her, and			
	no activity being				
		•			
	During an interv	riew on 3/29/2012 at 3:54			
	P.M., The Activ	ity Director indicated,			
		as only on a one to one			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 50 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	COMPL		
ANDILAN	OF CORRECTION	155196		LDING	00	04/02/	
		100100	B. WIN		ADDRESS STATE OF SORE	0 1/02/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	1	week for not more than					
	1	ites at a time. Resident #					
		ted for them to sit by her					
		er hand. She liked gentle					
	_	manicures, sensory type					
		rent texture balls that					
		her to squeeze. She liked and she liked the animals					
		but only the smaller					
	<u>-</u>	-					
		I not participate in group					
	activities because of her cognitive status. She enjoyed wheel chair rides especially						
		nt #26's daughter told					
		26 enjoyed classical and					
		usic and at times they					
		ic to her room during 1:1					
		t provided in her room at					
		ident #26 enjoyed being					
		n the sun room or the					
		ctivity Director stated,					
		ore willing to attend a					
	_	at included music." The					
		stated, "In my opinion 30					
		n one in room activities a					
		I have a consultant who					
	goes by the state						
	goes by the state	regulations.					
	During an interv	iew on 3/29/2012 at 3:54					
	P.M. the Activity	y Director was informed					
	Resident #26 had	d not been observed at an					
	activity for the p	ast four days.					
	Documentation v	was requested of all					
	activities Reside	nt #26 had attended					
	including 1:1 act	ivities for the months of					
	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 51 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
THIE TEXT	or condition	155196		LDING		04/02/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 0	
NAME OF I	PROVIDER OR SUPPLIER				HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	y, and March 2012.					
		of all activities provided					
		r the same months were					
	also requested.						
	On 3/30/2012 at	9:30 A.M., the January,					
	February, and March 2012 activity						
	calendars were re	eviewed. These					
	calendars indicat	ed eighty-four activities					
	which included r	nusic, church, hand					
	massages, manicures, pet visits, and						
	sensory stimulati	ion (all assessed as					
	interest of Reside	ent #26) were offered at					
	this facility on th	e A/B unit (where					
		ided) and/or in the					
	Solarium (where	Resident #26 was					
	assessed to enjoy						
		no was assessed to be					
	_	ff to anticipate her needs					
		ident on staff for mobility					
		it did not attend any					
l	facility provided	out of room activities.					
l	Resident #26's 1:	1 activity attendance					
	record for Decen	nber 2011 indicated					
	Resident #26 wa	s provided five in room					
	1:1 activities for	the month. Review of					
	the January 2012	activity attendance					
	record indicated	Resident #26 was					
	provided six in re	oom 1:1 activities for the					
	month. Review	of the February 2012					
	activity record in	dicated Resident #26					
	was provided for	ur 1:1 in room activities					
	for the month. R	Leview of the March 2012					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 52 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER			3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	Resident #26 wa 1:1 activities. During an interv. P.M., CNA #9 (O Assistant) stated go to activities. here in the eveni. The activity pers want to and if the usually say yes." when asked if this 3. Resident #37' reviewed on 10/2 Resident #37 wa and had current obut were not limit hip fracture, arth dementia, Alzhei depression, and a Resident #37's la set assessment (N indicated Reside assistance for beand required an a mobility on and had been assesse including reading magazines, lister around animals set.	"We ask if they want to We usually do activities ing time around dinner. On will ask them if they ey are up they will CNA #9 indicated yes included Resident #26. Is clinical record was 28/2012 at 10:00 A.M is admitted on 1/13/2011 diagnoses which included ited to a history of a left ritis, kyphoplasty, mer's disease, inxiety. Is annual minimum data MDS) dated 1/19/2012 in #37 required extensive in mobility, did not walk, assistance of one for off the unit. Resident #37 it to prefer activities is books, newspapers or using to music, being					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 53 of 78

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	E SURVEY PLETED	
		155196	B. WING		- 04/0	2/2012
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CO E HANNA AVE NAPOLIS, IN 46237	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	care plan which would participate sensory stimulations using her interest social interaction. Resident #37 enjexercise, going to programs and an longer appropriation unit due to sexual behaviors and requestioning due impairment. Ende participate in profession and adjust as need of monthly active her to and from the standard and care plan indicate extensive assist with living (adls), deconfunctional and confunctional and co	indicated Resident #37 e in 1:1 programs for fon to decrease anxiety it in animals, music, and as. Approaches included: oyed musical programs, to the hair salon, spiritual imal visits. She is no te for programs off the ally inappropriate petitive calling out- to short term memory courage Resident #37 to ograms on the unit. conse to the plan of care aded. Provide a calendar ity programs. Transport the hair salon. Ilem originally dated the current March 2012 ted Resident #37 required with all activities of daily reased mobility, and ognitive impairments. th locomotion to and and meals. 3/26/2012 at 2:16 P.M.: as observed in bed. 3/27/2012: At 10:23 37 was observed in bed				
	Maury Povich or	the television (TV). At				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 54 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155196	B. WIN	G		04/02/	2012
NAME OF F	PROVIDER OR SUPPLIER	4			DDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	•	(Jerry Springer on TV) the was observed in bed.					
	(Maury Povich of at the dining root activity, or staff provided. At 12 with talk show o	3/28/2012 at 10:06 A.M. on TV, 11:50 A.M. sitting m table with no music, interaction being 220 P.M. in bed eyes open n talking about "I Beat 30 P.M. in bed with Jerry					
	37 was observed A.M.,10:41 A.M on with subject V	3/29/2012: Resident # in bed at 9:40 in 11:15 A.M. (talk show Whose My Baby's Daddy) udge Joe show on TV).					
	12:00 P.M. sittin table with no mu	s observed on 3/30/12 at g at the dining room sic playing, no one her, and no activity being					
	A.M. documenta the Activity Dire Resident #37 had	tiew on 4/2/2012 at 11:00 tion was requested from ector of all activities d attended including 1:1 months of January, arch 2012.					
		1:00 A.M., the January, arch 2012 activity eviewed. These					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 55 of 78

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	activities which visits, trivia, and assessed as inter offered at this far (where Resident 37 who was assess staff for mobility not attend any far room activities. Review of the Jarattendance recons was provided six for the month. If 2012 activity recompared activities for the March 2012 activity	riew on 3/29/2012 at 3:00 certified nursing assistant if they want to go to sually do activities here me around dinner. The will ask them if they want e up they will usually say indicated yes when asked			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 56 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER		p. why	3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	and had current of but were not limit accident (stroke) aphasia, deafness on hemodialysis, hypertension, coordisease, coronary fibrillation, hyper post aspiration procession of the coronary fibrillation, hyper post aspiration of the coronary fibrillation of the communication of the communication of the communication of the communication of the participate in a litimes a week to participate in cluded: the plan of care at Resident #129's facility Resident scratch off lotter outdoors. A current care plad 1/26/2012 indicating paired cognition making related to the coronary fibrillation of the coronary fibrillation.	an dated 3/30/2012 nt #129 had a need for a ram to provide sensory o a diagnoses of acute ascular accident-stroke) aresis and impaired related to deafness. A sident #129 would :1 activity program three					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 57 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155196	B. WIN	G		04/02/2012
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			3525 E	HANNA AVE	
	EIM HEALTH & LIV				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BETCERCT	DATE
		nity to make simple				
	decision for self throughout the day.					
		aded allowing him time				
	to absorb and respond to information.					
	Observations on 3/27/2012 from 9:00					
	A.M. through at least 3:00 P.M. Resident					
		the building for dialysis.				
	Was out of	the cantaing for alarysis.				
	Observations on	3/28/2012: Resident				
	#129 was observed in bed at 10:13 A.M.					
	11:00 A.M., 1150 A.M., 12:00 P.M. 1:34 P.M., 2:00 P.M.					
	7, 2.00 1					
	Observation on 3	3/29/2012 from 9:00				
	A.M. through at	least 3:00 P.M. Resident				
		the building for dialysis.				
	Observations on	3/30/2012: Resident				
	#129 was observ	ed in bed at 9:40 A.M.,				
	10:41 A.M., 11:1	5 A.M. and 3:00 P.M.				
	During an interv	iew on 4/2/2012 at 11:00				
		tion was requested from				
	1	ector of all activities				
		ad attended including 1:1				
	activities since h	is admission.				
	On 4/2/2012 at 1	1:00 A.M., Resident				
		tendance records were				
	1	month of March 2012.				
		ad not attended any				
		since his admission or				
	nad been provide	ed with 1:1 in room				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 58 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 04/02	LETED		
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF	PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE		
	activities. 3.1-35(g)(2)							
	21. 21. (8)(=)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 59 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MI A. BUII B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPL 04/02 /	ETED	
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE JAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
F0309 SS=D	WELL BEING Each resident m must provide the services to attair practicable phys psychosocial we the comprehens care. Based on observ clinical record re	Il-being, in accordance with ive assessment and plan of ation, interview, and eview, the facility failed	F03	09	F309-483.25 <u>PROVIDE</u> CARE/SERVICES FOR HIGHEST WELL BEING I.		04/29/2012
	to maintain the p	es ordered by a physician hysical well-being for 1 eviewed for services in a total sample of 35.			Resident #129 no longer resides at the facility. II. All residents with orders for support equipment have bee identified and the physician orders are being followed. III Systemic changes include: residents with an order for	en 's I.	
	Resident #129's of reviewed on 3/28 Resident #129 where and had current of but were not limit accident (stroke) aphasia, deafness on hemodialysis, hypertension, condisease, coronary fibrillation, hypertension, hy	clinical record was 8/2012 at 10:30 A.M. as admitted on 3/13/12 diagnoses which included ited to cerebrovascular with right hemiparesis, s, end stage renal disease diabetes mellitus, ronary pulmonary v artery disease, atrial rlipidemia, and status			support equipment will have the equipment listed on the C.N.A. assignment sheets. T.C.N.A. assignment sheets ar updated daily (Monday throu Friday) at the clinical meetin and as needed by the charge nurses during non-business hours. The Charge Nurse ar Administrative Nursing staff will make rounds daily for compliance with the ordered support equipment being utilized. Education will be	The re ugh g; e	
	indicated Reside	der dated 3/19/2012, nt #129 was to have the for support while up in the			provided to nursing staff regarding updating and utilizing the C.N.A. assignme sheets and completing roundaily for compliance with the ordered support equipment	ds	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 60 of 78

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		ONSTRUCTION 00	(X3) DATE SU COMPLE	TED
		155196	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/02/2	U 12
NAME OF I	PROVIDER OR SUPPLIE	R			HANNA AVE		
ALTENH	EIM HEALTH & LIV	/ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	10:20 A.M., Resisting in his what tray attached to an interview at a practical nurse) been looking for (certified nursing they had been may buring an interval occupational The "Whenever he is the tray on. He sublexation on the needed tray to keep position so it with the position so it with	nerapist #11 stated, s in chair he should have has a shoulder he right. That is why he eep his arm in a good			being utilized. IV. The Unit Manager or designee will complete daily rounds (Monothrough Friday) on the unit to monitor for compliance with the ordered support equipme being utilized per the physici orders. Any concerns will be addressed. The results of the reviews will be discussed at the monthly facility Quality Assurance meetings and frequency and duration of the reviews will be adjusted as needed. Addendum requeste for F309:The results of the reviews will be discussed at the monthly Quality Assuran Committee meeting for a tota of 12 months. After 12 month the Committee may determin whether to discontinue the audits if 100% compliance we achieved. Completion date: April 29, 2012	ent dan e e e d ce al as,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 61 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDING B. WING	00	COME	E SURVEY PLETED 2/2012				
ALTENHI		ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S' CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	3.1-37(a)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 62 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE S COMPLI		
		155196	A. BUI B. WIN	LDING G		04/02/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE JAPOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0323 SS=G	The facility must environment rem	ERVISION/DEVICES ensure that the resident nains as free of accident					
	receives adequa	ssible; and each resident te supervision and es to prevent accidents.					
	Based on intervie	ew and record review, the	F03	23	F323-483.25 (h) (The facility		04/29/2012
	facility failed to	supervise and prevent an			respectfully requests a face		
	accident/fall, by	not providing stand by			face IDR) FREE OF ACCIDENT HAZARDS/SUPERVISION	NT	
	assistance while	toileting a resident for 1			/DEVICES I. Resident A no		
	of 4 residents rev	viewed for falls resulting			longer resides at this facility	, <u>. </u>	
	in resident A sus	taining multiple bruises			II. All residents at risk for fa	alls	
	on multiple extre	emities, back, and head			have been identified and are		
	and a subdural he	ematoma [bleeding in the			provided with supervision to)	
	brain]. (Residen				prevent an accident/fall including providing stand by	,	
	, ,	,			assistance while toileting as		
	Findings include	:			assessed by therapy. III. The systemic change includes: A	e	
	The clinical reco	ord for Resident A was			therapy recommendations for nursing are discussed at the		
	reviewed on 3/27	7/11 at 3:30 p.m.			daily (Monday through Frida		
					clinical meeting. All new	,	
	The diagnoses for	or Resident A included,			orders are reviewed at this		
	but were not limi	ited to: trochanter			meeting, which includes		
	fracture, muscle	weakness, and recent			therapy order changes and recommendations for nursin		
	history of right h	ip replacement.			In addition, any resident that	_	
					in therapy and has any	13	
	The ER (Emerge	ency Room)/hospital			changes in recommendation	ıs	
	, -	11/12, indicated that			for nursing are discussed wi		
		ented to the ER with			the interdisciplinary team for	r	
		on multiple extremities,			directing the care plan and		
	_	nd a subdural hematoma.			C.N.A. assignment sheets. Residents with changes in		
		al care progress note,			status are also discussed at		
	_	dicated a subarachnoid			this meeting for necessary		
	auca 5/11/12, III	anoused a suburaciiiioid			reassessment and revision of	of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 63 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SUR	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DINC	00	COMPLETE	D
		155196		LDING		04/02/201	12
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
		(NIC COMMUNITY)			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hemorrhage and	right breast hematoma.			the plan of care. Revisions		
					necessary for the plan of car	e	
	A facility progress, dated 3/10/12 at 9:20				and C.N.A. assignment sheet	ts	
					are made after completion of	•	
	· ·	res (resident) [sic] being			this meeting. Education will		
	•	m care, restorative care			provided to nursing staff and		
	CNA attempting	to get res up and res 'legs			therapy regarding the system		
	just buckled' [sic	e] res was lowered to the			changes mentioned above. I'		
	floor via CNA. v	vith gait belt on, res was			The Unit Manager or design	ee	
		gotten up off the floor			will audit all care plans and		
		o [sic] res has no red			C.N.A. assignment sheets		
					regarding new orders for		
		ated areas noted, all			changes in therapy	_	
		s notified, res has call			recommendations for nursin as well as for any changes in	-	
	light in reach"				recommendation for nursing		
					discussed at the clinical star		
	A facility progre	ess note, dated 3/11/12 at			up meeting. This audit will		
		ted an "aide came down			occur daily (Monday through		
	· ·	fied nurse that there was a			Friday). In addition, the Unit		
					Manager or designee will ma		
	_	round. When the nurse			rounds daily, Monday throug		
		room, the resident was			Friday, to review that fall		
	lying on the floo	r holding her head in			interventions are in place an	d	
	pain. ROM (ran	ge of motion) on all			being followed. The weeken	d	
	extremities was	good. Bruising on right			manager will also make roun	ds	
	forehead measur	res 6 cm (centimeter) x 6			on Saturday and Sunday to		
		g. Doctor notified.			monitor the same. Any		
		end her out. POA and			concerns will be addressed.		
					The results of the reviews wi	II	
	Pharmacy notifie	ed."			be discussed at the monthly		
					facility Quality Assurance		
	In an interview with the DoN (Director of				Committee meeting and		
	Nursing), on 3/29/12 at 12:00 p.m., she				frequency and duration of th	e	
	indicated stand by assistance is				results will be adjusted as needed. Addendum requeste	ad	
					for F323:The results of the	-u	
	communicated with the staff per the A/B/C Wing Resident Information Sheet.		reviews will be discussed at the				
	A/D/C Willig Kes	sigent information sheet.			monthly Quality Assurance	`	
					Committee meetings for a total	l of	
	In an interview v	with PT #2, on 3/29/12 at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155196		LDING	00	04/02/2012
		100100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1702/2012
NAME OF I	PROVIDER OR SUPPLIER				HANNA AVE	
	EIM HEALTH & LIV				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
	`				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
PREFIX TAG	REGULATORY OR 12:20 p.m., she i #A was residing stand by assistan commode and th passed on to nurs meetings. PT #2 by assistance me to provide immer needed. In an interview v 12:40 p.m., she i A was residing in stand by assistan bedside commod information is pa daily meetings an #3 also indicated means within arr immediate assist The OT (Occupa -Therapist Progre Summary, dated "Current Level o Toileting-Genera able to safely per utilizing grab bar (contact guard as	ess Report and Discharge 3/09/12, indicated, for f Function for Self Care: al," that Resident A is form all toileting tasks are and required CGA esistance).		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	DATE ne lits
	In a interview with OT #3, on 3/29/12 at 1:20 p.m., OT #3 indicated on the					
		nary for Resident A, that				
	Resident A still r	•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 65 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155196	A. BUI B. WIN			04/02/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	grab bars while toileting,					
	which also means CGA (contact guard						
	assistance). OT #3 reiterated that stand						
	by assistance me	eans that staff is to be					
	within arm's leng	gth, to provide assistance,					
	if needed, immed	diately.					
	The C Wing Res	sident Information Sheet,					
	_	d, indicated Resident A					
		erred and toileted with 1					
		as no further information					
	_	dent while toileting to					
		dent needed stand by					
		on the toilet per OT and					
	PT's recommend	lation.					
	In an interview v	with CNA #1, on 3/29/12					
	at 3:40 p.m., she	indicated she transferred					
	Resident A to a l	bedside commode and					
	went into bathro	om to retrieve washcloths					
	and to start the w	vater to clean the resident					
		rater was running, she					
	_	I found resident on the					
	1	er head. CNA #1 indicated					
		has been more confused					
		ras reported to her that the					
	1	'assisted fall," the					
		*					
	-	NA #1 also indicated that					
	she did not know that Resident #A was a						
l	stand by assist.						
l	In another interv	riew with CNA #1, on					
	3/30/12 at 12:15	p.m., she reiterated that					
		pecome more confused					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet Page 66 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMI	E SURVEY PLETED 2/2012
	ROVIDER OR SUPPLIEF	ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP (HANNA AVE APOLIS, IN 46237	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	regulatory or within the recent			CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 67 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (X3) DATE SUI COMPLETI 04/02/20			ETED		
	PROVIDER OR SUPPLIER EIM HEALTH & LIV			3525 E	HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=F	The facility must (1) Procure food considered satist local authorities; (2) Store, prepar under sanitary co Based on observa	RE/SERVE - SANITARY - from sources approved or factory by Federal, State or and e, distribute and serve food	F03	71	F371-483.35 (i) FOOD PROCURE, STORE/PREPARE/SERVE-SA		04/29/2012
	by not wearing hand serving food had to the potent skilled nursing remain dining room to provide a sanit by touching food serving food. The affect 40 of 50 reand B wing dining failed to provide to test the 3 compand maintain the temperature for secompartment sand the potential to a that solely utilized by the kitchen. (If #48)	airnets while scooping from a steam table. This ial to affect 8 of 71 esidents that dined in the m. The facility also failed tary manner to serve food with bare hands while is had the potential to esidents that dine in the A mag room. The facility also appropriate testing strips partment sanitizing sink appropriate water sanitization in the 3 mitizing sink. This had ffect 68 of 71 residents edining services provided Resident #32, #11, and			TARY I. Dietary Aid #4, 5, an were offered education regarding utilizing hairnets when scooping and serving food from the steam table. The Dietary Manager was offered education regarding the use the correct test strip with the solution for testing the 3 compartment sink. Housekeeping Supervisor #1 and C.N.A. #16 were offered education regarding not touching food with their bare hands during meal assistance. II. All dining services associates wear hair nets when scooping and serving food from the steam table to residents. All associates serviced without touching food with bare hands. Dietary staffare using the appropriate testing strips to test the 3 compartment sanitizing sink and maintain the appropriate water temperature for sanitization in the 3 compartment sanitizing sink.	ne of 7 e. en	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 68 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155196	B. WING			04/02/	2012
NAME OF I	DDOMDED OD CHIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		/12 at 12:00 p.m., Dietary			III. The systemic change		
	Aide #4, Dietary Aide #5, and Dietary				includes: The correct test		
	Aide #6, were of			strip is now being utilized to			
	serving food from the steam table to				measure the pH of the 3 sin compartment, and the log v		
	_	t hairnets on throughout			be utilized to document the		
		service in the main dining			correct pH to ensure the		
		service in the main uning			correct level. • The Dietary		
	room.				Manager or designee will		
					monitor serving at steam		
	In an interview v	with Dietary Aide #4, on			tables for compliance with	use	
	3/30/12 at 12:45	p.m., she indicated that			of hair nets. Nursing		
	they did not hav	e to wear hairnets while			Administration will monitor		
	scooping and ser	rving food and they were			dining room service for		
	told this about 8	•			compliance with not touchi	ng	
	lora tino accur o	monulo prior.			food with bare hands.		
	On the Desident	Census and Conditions			Education will be provided		
					dietary staff regarding use	of	
		ovided by the Administer			the correct test strip to		
	on 3/26/12 at 4:3	30 p.m., it indicated that 3			measure the pH of the 3 sin		
	residents of 71 h	ad tube feedings.			compartment and use of the log to document the correc		
					as well as use of hair nets	ι рп	
	On a list, titled A	A/B wing, Shift Change			when serving at any steam		
	· ·	ovided by the DoN			table. Education was provide	led	
		sing) and Dietary			to staff regarding not touch		
	,	0/12 at 12:25 p.m., it			food with bare hands when	_	
					assisting residents with me	al	
		50 residents, dined in A/B			service. IV. The Director of		
	wing dining room	m.			Dining Services or her		
					designee will complete an a		
	On a list, titled F	Resident Roster, provided			5 days / week to monitor fo		
	by the DoN and	Dietary Manager on			hair nets are utilized, correc	et	
	1 -	p.m.,it indicated 8 of 71			test strips are utilized and		
		IDR next to their name			proper handling of foods ar	е	
	ate in the main d				maintained accordingly to	will	
		ming 100m.			regulations. The daily audit		
					continue for 30 days and th will be completed 2 times a		
		with the Administrator, on			week for additional 60 days		
	4/2/12 at 11:10 a	a.m., she indicated that			wook for additional or days	,	

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILD B. WING	ING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012	
	ROVIDER OR SUPPLIER			3525 E I	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	serving food in the because it was re- comments regard of hairnets in the Administrator was	worn while scooping and the main dining room selated to resident's ding dignity and the use of dining room. The as unable to provide on regarding which is and when.			then monthly thereafter. The reviews of the findings from the audits will be discussed at the monthly Quality Assurant Committee meeting and duration of the results will be adjusted as needed. Addendum requested for F371:The results of the reviewill be discussed at the monthly Quality Assurance Committee meetings for a tot of 12 months. After 12 month the Committee may determin whether to discontinue the audits if 100% compliance was achieved. Completion date: April 29, 2012	at ce ws ws tal hs,
	3/26/2012 at 12:0 Assistant #5 scool from the steam to worn. The steam labeled 'pantry' room. At 12:15 pscooped up vanil net worn while stroom. 3. During a kitch Dietary Manager a.m. pots and para a kitchen sink co compartments for	f the lunch time meal on 00 p.m. indicated Dietary oped up food directly able with no hair net table was kept in a room ight off the main dining o.m., Dietary Assistant #4 la ice cream with no hair erving out in main dining the observation with (DM) on 3/30/12 at 9:45 has were being washed in insisting of 3 rewash, rinse and DM measured the ph of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 70 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155196	B. WIN			04/02/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		o have contained a					
		on but the test strip					
		nstead of changing color					
		unt of ph. She indicated					
		ted using the 1 gallon					
	bottle of Quat-cl	ean solution they had					
	received on 3/4/1	12 and that the new strips					
	they received on	3/25/12 were apparently					
	not working with	the solution (then					
	observed to be ha	alf empty).					
	The log for testir	ng the ph of the sanitizing					
	solution for the r	nonth of March was					
	observed hanging	g on the wall indicating					
		all days of the month.					
	-	sked how the ph levels					
		measured without the					
		strips she stated "the staff					
		questimating [sic] the ph					
		d posted on the wall."					
		of the water in the 3					
		iken measuring 95					
		vash water and 104					
	degrees for the w						
	1 ~	ise and samuzer					
	compartments.						
	At 1:00 n m	2/20/12 on interview was					
	_	3/30/12 an interview was					
		he Administrator (ADM)					
	<u> </u>	no indicated she was not					
	_	propriate sanitizing strips					
	_	sed in the sanitizing sink					
	•	til the DM brought it to					
		lier in the day but that she					
	was concerned a	bout the falsification of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N44811

Facility ID: 000103

If continuation sheet Page 71 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/02/	ETED	
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	the log and woul corrected immed	d make sure that it was iately.					
	and procedure for dish handling was The policy indicas sanitizing sink sholeach (50 ppm) 400 ppm) or a holeach (50 ppm) or a holeach (50 ppm) and appropriate Quat-clean solution was not using the sink", but she we correct strips in the sink", but she we correct strips in the sink and should be solved the solved the sink and should be solved the solved th	h observation of /12 at 11:53 a.m. apervisor #17 and CNA red assisting residents. apervisor #17 buttered ands for Resident #32 At this time Cook#18 and identified CNA #16 aching food with bare and the way to the facility. by received on 4/2/12 at attes: "All Dietary					
		ractice standard sanitary cedure: All employees					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 72 of 78

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 04/02	E SURVEY PLETED 2/2012
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CO HANNA AVE IAPOLIS, IN 46237	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	shall: 1. Wear hair restraints/nets and clean clothes 9. Use utensils to handle food."				
	3.1-21(i)(3)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **N44811**

Facility ID: 000103

If continuation sheet

Page 73 of 78

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI		URVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155196	B. WING			04/02/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
					HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY				INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0273	410 IAC 16.2-5-5	• •					
		onal Services - Deficiency					
		ration and serving areas					
		in residents ' units) are					
		cordance with state and local					
	including 410 IA	afe food handling standards,					
	_	ation, interview, and	R02	73	R-273 410 IAC 16.2-5-5 (f)		04/29/2012
		e facility failed to			FOOD AND NUTRITIONAL		
	· · · · · · · · · · · · · · · · · · ·	y manner to serve food			SERVICES-DEFICIENCY		
	•	airnets while scooping			_		
	,	from a steam table. This			I. Dietary Aid #4, 5, ar		
	•				6 were offered education regarding		
		ial to affect 56 of 59			utilizing hairnets when scooping		
		ents that dined in the main			and serving food from the steam		
	dining room. Th	e facility also failed to			table.		
	provide appropri	ate testing strips to test			The Dietary Manager was offered		
	the 3 compartment sanitizing sink and maintain the appropriate water				education during the survey regarding the use of the correct tes		
					strip with the solution for testing		
temperature for sani		-			the 3 compartment sink.		
		itizing sink. This had		All dining services associates will			
	•	ffect 59 of 59 residents			wear hair nets when scooping and		
	that utilized the d				serving food from the steam table		
	that atmized the c	ming facilities.			to residents.		
	Eindings in also 1.				II. All dining services		
	Findings include	-			associates wear hair nets when		
					scooping and serving food from the	!	
	•	servation of dining			steam table to residents.		
		12 at 12:00 p.m., Dietary			Dietary staff are using the		
	Aide #4, Dietary Aide #5, and Dietary				appropriate testing strips to test the 3 compartment sanitizing sink		
	Aide #6, were ob	served scooping and			and maintain the appropriate wate	r	
	serving food from	n the steam table to			temperature for sanitization in the	•	
		t hairnets on, throughout			3 compartment sanitizing sink.		
		ervice in the main dining			III. The systemic change		
	room.				includes:		
	100111.				The correct test strip is now being		
	т	'.I D'			utilized to measure the pH of the 3		
	in an interview w	vith Dietary Aide #4, on			sink compartment, and the log will		
			1				

State Form Event ID: N44811 Facility ID: 000103 If continuation sheet Page 74 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED
155196		155196	B. WIN			04/02/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					HANNA AVE	
ALTENHEIM HEALTH & LIVING COMMUNITY					APOLIS, IN 46237	
ALILINII	- LINITICALITI & LIV	ING COMMONT I		INDIAN		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	3/30/12 at 12:45	p.m., she indicated that			be utilized to document the correct	:
	they did not have	e to wear hairnets while			pH to ensure the correct level.	
	scooping and ser	ving food and they were			IV. The Dietary Manager	
	told this about 8	•			or designee will monitor serving at	
		monus priori			steam tables for compliance with	
	T	of a list titled Desident			use of hair nets.	
		w of a list titled, Resident			Nursing Administration will monito	
		from the DoN (Director			dining room service for compliance	
	of Nursing) and	Dietary Manager, on			with not touching food with bare	
	3/30/12, at 2:45	p.m., it indicated that 56			hands.	
	of 59 residents w	vith the word, always,			Education will be provided to	
	next to their name, always dined in the				dietary staff regarding use of the	
	main dining room.				correct test strip to measure the pl	
		11.			of the 3 sink compartment and use	
					of the log to document the correct pH as well as use of hair nets when	
	In an interview with the Administrator, on 4/2/12 at 11:15 a.m., she indicated that hairnets are not worn while serving food in the main dining room because it related				serving at any steam table.	
					Education was provided to staff	
					regarding not touching food with	
					bare hands when assisting resident	s
	to resident's comments regarding dignity				with meal service.	
		nirnets in the dining room.			V. The Director of Dinin	g
		or was unable to provide			Services or her designee will	
		on regarding which			complete a daily audit 5 days /	
		0 0			week to monitor for: hair nets are	
	residents said thi	is and when.			utilized, correct test strips are	
					utilized to measure pH in 3 sink	
					compartment, and proper handling	
	2 01	f the lunch time meal on			of foods are maintained accordingly	У
					to regulations. The daily audit will	
		00 p.m. indicated Dietary			continue for 30 days and then will	
	Assistant #5 sco	oped up food directly			be completed 2 day/ week for	
	from the steam to	able with no hair net			additional 60 days, then 1	
	worn. The steam	table was kept in a room			day/week for a total of 12 months	
	labeled 'pantry' right off the main dining				of auditing/monitoring.	
		o.m., Dietary Assistant #4			The reviews of the findings	
	_	•			from the audits will be	
		lla ice cream with no hair			discussed at the monthly	
	net worn while s	erving out in main dining			Quality Assurance Committee	<u>, </u>
					wasney rosarance committee	- 1

State Form Event ID: N44811 Facility ID: 000103 If continuation sheet Page 75 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			LDING	ONSTRUCTION 00	(X3) DATE S COMPLI 04/02/2	ETED	
	PROVIDER OR SUPPLIED	I R YING COMMUNITY	p. wiiv	STREET A 3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	room. 3. During a kitch Dietary Manage a.m. pots and para a kitchen sink compartments for sanitizing. The street the sink section sanitizing solution remained clear into show the amounthey had just star bottle of Quat-clareceived on 3/4/ they received on not working with observed to be had the phof 200 for When she was a could have been appropriate test must have been [sic] [sic] [sic] written and post temperature of the was then taken resulted.	then observation with r (DM) on 3/30/12 at 9:45 ms were being washed in onsisting of 3 or wash, rinse and DM measured the ph of to have contained a on but the test strip instead of changing color runt of ph. She indicated red using the 1 gallon ean solution they had 12 and that the new strips 13/25/12 were apparently in the solution (then			meeting and duration of the results will be adjusted as needed. Completion date: April 29, 2012	TE	
		er compartments.					

State Form Event ID: N44811 Facility ID: 000103 If continuation sheet Page 76 of 78

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155196	B. WIN			04/02/	2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY					APOLIS, IN 46237		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES OV MUST BE BEDGEDED BY ELL I		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	At 1:00 p.m. on a conducted with to of the facility who aware that the apwere not being used compartment until her attention early was concerned at the log and would corrected immed. On 3/30/12 at 1:1 and procedure for dish handling was The policy indicas antitizing sink shall bleach (50 ppm) 400 ppm) or a hour 170 degrees. Shafound appropriate Quat-clean solutions was not using the sink", but she was correct strips in the facility policy 10:00 a.m. indicate mployees will procedures. Processhall:	3/30/12 an interview was the Administrator (ADM) to indicated she was not appropriate sanitizing strips sed in the sanitizing sink till the DM brought it to iter in the day but that she bout the falsification of d make sure that it was iately. 15 p.m. the facility policy or cleaning, sanitizing and as reviewed with the DM. ated that the sink 3 mould contain a chlorine or quat sanitizer (200 to be water temperature of the also stated that she tender that they used the sould see that they used the she future. The preceived on 4/2/12 at the strips that match the sould see that they used the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future. The preceived on 4/2/12 at the strips that match the she future.					

State Form Event ID: N44811 Facility ID: 000103 If continuation sheet Page 77 of 78

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2012				
NAME OF P	DDOWNER OF GIRES TO		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	PROVIDER OR SUPPLIER			HANNA AVE				
	EIM HEALTH & LIV		INDIANAPOLIS, IN 46237					
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			

State Form Event ID: N44811 Facility ID: 000103 If continuation sheet Page 78 of 78